VIRGINIA

Remarks by Nicole Riley, Virginia State Director with the National Federation of Independent Business

for the Virginia Health Reform Initiative Meeting

May 3, 2012

Good Morning. My name is Nicole Riley. I'm the Virginia State Director for the National Federation of Independent Business. We are Virginia's leading small business organization representing approximately 6000 small business owners throughout the Commonwealth.

I want to thank Secretary Hazel and Cindi Jones for asking me to participate on this panel. The increasing difficulty in accessing affordable health care is one of the top concerns among our members (Its right up there with taxes). And certainly the essential health benefits package will have a significant impact on the costs associated with any plan that is offered in and out of the Health Benefit Exchange.

My remarks today will first paint a picture of the reality facing small business owners in today's health care market and how mandated health benefits impact their chances of finding affordable health care coverage. The second part of my remarks will focus on what small businesses want regarding the essential health benefits package while touching on the analysis done by PriceWaterhouseCooper and comments submitted to the Task Force.

Reality facing Small Businesses in today's Healthcare Market

A health insurance mandate requires a policy to cover specific health care benefits, providers, or patient populations. While mandates make health insurance more comprehensive, they also make it more expensive. Mandates require insurers to pay for care consumers previously funded out of their own pockets and require consumers to pay for benefits they might never use.

The "essential health benefits" package (EHB package) will dictate what all health insurance plans offered in small and individual group markets must cover. The more comprehensive the package, the more costly the basic plan will likely be. This is where the rubber meets road.

Regardless of our opinions of this health care law, we realize that unless this package is defined with care, the most basic plans will be unaffordable and out of reach to thousands of Virginians.

This is problematic, given that U.S. businesses and workers are already buckling under the weight of staggering health care costs. From 2000 to 2011, average annual health insurance premiums more than doubled from $4,819 to $10,944 for employers, according to the Kaiser Family Foundation, and from $1,619 to $4,129 for workers.

Just recently, the Kaiser Family Foundation released their "2011 Employer Health Benefits Survey" that showed a 9% increase from 2010 in the annual premiums for employer-sponsored family health coverage.

In the last 20 years, there's been a proliferation of state mandated benefits. According to the Council for Affordable Health Insurance (CAHI) which began tracking state mandates in 1992, there were only 850 mandates across all 50 states – it's grown to 2,262 – that's an increase of 166%. And of that total – over a 100 were just added this past year.

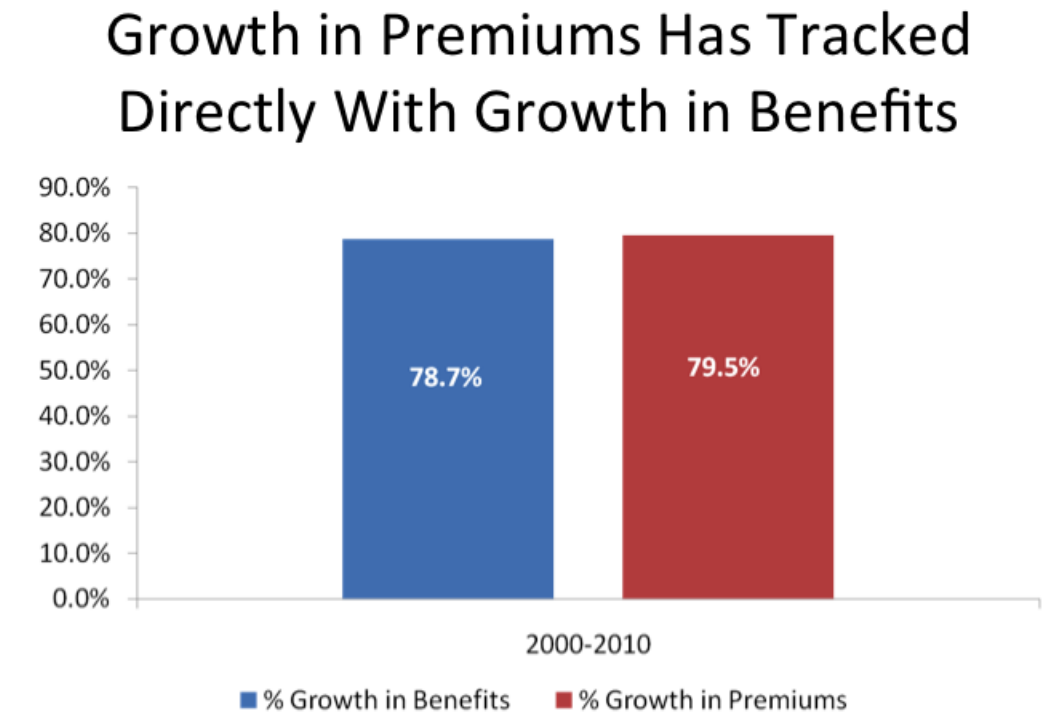
Based on their annual analysis, mandated benefits currently increase the cost of basic health coverage from slightly less than 10 percent to more than 50 percent, depending on the state, specific legislative language, and type of health insurance policy.
While Virginia can be proud of its top status as the best state to do business, raise a family, and make a living – we shouldn't be proud of the fact that Virginia now tops the list with Rhode Island for the most mandated benefits at 70.

Most Mandated Benefits		**Least Mandated Benefits**		**Most Popular Mandates**		**Least Popular Mandates**	
Rhode Island	70	Idaho	13	Mammography Screening	50	Breast Implant Removal	1
Virginia	70	Alabama	19	Maternity Minimum Stay	50	Cardiovascular Disease Screening	1
Maryland	67	Michigan	23	Breast Reconstruction	49	Circumcision	1
Minnesota	65	Hawaii	24	Mental Health Parity	48	Gastric Electrical Stimulation	1
Connecticut	63	Utah	26	Alcohol & Substance Abuse	46	Organ Transplant Donor Coverage	1

(Source: CAHI - Health Insurance Mandates in the States, 2011)

The sheer number of mandates in Virginia will make it difficult for the Commonwealth to deliver on one of the key promises repeatedly made by supporters of the new federal health care reform law: that it would provide all Americans with affordable health coverage. The recent guidance from the U.S. Department of Health and Human Services (HHS) on the design of the essential health benefit plans ostensibly grants states the flexibility to craft affordable benefit packages suitable to their populations. But those states that adopt their current small employer health insurance plan for this purpose will shackle consumers with coverage that is already overloaded with dozens of existing state mandated benefits. These mandates, layered on top of the new federal coverage mandates, will inevitably drive up costs for everyone. This will actually worsen, rather than fix, the issue of health insurance that is priced out of the reach of many individuals and small employers.

And in case you were wondering if the costs of mandated benefits really impact the cost of health care – look at the numbers from CMS' National Health expenditure data: the growth in premiums tracked directly with the growth in benefits. From 2000 to 2010, the growth in premium costs rose 79.5% and benefits grew by 78.7%.



Source: CMS' National Health Expenditure Data

Also, look at the number of small businesses offering health benefits. They've decreased dramatically over the past decade. In 2001, 68 percent of small employers offered health benefits. By 2010, that number had dropped to 39 percent of small employers. One can expect that as costs continue to increase, the number of small businesses discontinuing health benefits will increase or at the very least more employers will be forced to pass the increased costs on to employees – who have only seen their wages increase by only 34% while annual health premiums have increased 113%.

For small business, a perpetual irritation is the fact that state mandates apply mostly to small businesses and individuals (including the self-employed). Most big businesses, labor unions, and governments are self-insured, and, therefore, exempt under ERISA. The essential health benefits package appears to compound this inequity.

Most small-group and individual policies must cover the entire EHB package, with no coverage limits and an actuarial value of 60 percent or higher. States will still have the discretion to add additional mandates on top of the EHB package. In contrast, plans obtained in the self-insured and fully-insured large-group (over 100) markets apparently do not have to include all the EHB items. They can't impose annual or lifetime coverage limits on any EHB services that they do cover, but it appears that they can omit EHB items from their coverage. This would seem to create a powerful motive to omit EHB items that are rare, but terribly expensive – a luxury small business will not share.

What Small Business Wants in the Essential Health Benefits Package

The bottom line: **Affordability is crucial**. Rising health care costs are the most significant barrier to obtaining and providing health care coverage.

We are advocating for a benefits package that is affordable and flexible enough to allow employers and individuals to obtain and maintain health coverage.

That's not just the view of businesses struggling under the weight of climbing health care costs and a weak economy. That's the view of the key federal advisory panel, the Institute of Medicine (IOM), an independent board advising the White House and HHS on this essential benefits package. The institute strongly warned against requiring costly excessive benefits starting in 2014 in its report in October.

"Costs must be taken into account," the 18-member panel wrote. "Unless we are able to balance the cost with the breadth of benefits, we may never achieve the health care coverage envisioned in the Affordable Care Act. If the benefits are not affordable, fewer individuals will buy insurance. And if health care spending continues to rise so rapidly, the benefits will begin to erode."

MIT Economist, Jonathan Gruber stated in an article last year that for every 10% increase in the cost of the essential health benefits package government subsidies will increase by $67 billion over 10 years. *(Source: MIT economist Jonathan Gruber, "Health Law Cost Still a Wildcard," Politico, 3/29/11)*

NFIB urges careful consideration as the benefit package is defined.

First, it must be affordable. For Virginia's consumers, Virginia's small businesses and Virginia's economic vitality.

Next, the package should make it easier, not prohibitive, for employers to offer and individuals to obtain health coverage. America's 6 million small businesses and 15 million self-employed individuals must have the freedom to choose plans that meet their benefit needs and their budgets.

Specifically, any essential health benefit package implemented in the Commonwealth should not be required to cover state-mandated health benefits that exceed the federal definition of essential benefits.

In fact, Virginia should institute the **most affordable** standard of mandated benefits allowable under Federal law.

A standard that does otherwise would make health coverage more expensive for small employers, limiting their ability to create jobs or foster growth. Additionally, the resulting increase in costs would be passed along to employees.

The matter truly comes down to a "generosity versus affordability" dynamic. Think about it in terms of car manufacturers – if you were to require all auto manufacturers to make cars with sunroofs, automatic transmissions and leather, heated seats – cars are going to be more expensive. What if someone wants to buy a car without all the bells & whistles because frankly – that's all they can afford?

We disagree with PWC's report that suggests additional benefits such as coverage for gastric bypass surgery; acupuncture; in-vitro fertilization, applied behavioral analysis; and hearing aids should be considered as covered benefits under the benchmark plan.

Requiring exchanges to cover benefits in excess of federal definitions only serves to widen the gap between those plans offered by small and large businesses as I mentioned earlier. Small businesses already pay, on average, 18% more for health insurance than their larger counterparts.

HHS has chosen to allow the states, rather than the federal government, to structure their own EHB package. Structuring models have been developed using private market coverage options in use today to serve as benchmarks. HHS has proposed four benchmark plans for state implementation of the EHB package.

Under the "Bulletin" issued by HHS, states are to choose one of the following four benchmark plan types: (1) any of the largest 3 State employee health benefit plans by enrollment; (2) any of the largest 3 national Federal Employee Health Benefits Program plan options by enrollment; (3) the largest insured commercial non-Medicaid HMO operating in the State; or (4) the largest plan by enrollment in any of the three largest small-group insurance products in the State's small-group market.

Benchmark plans (1) and (2) are not fiscally viable options. State and federal employee health benefits plans cover a wide array of expensive procedures that are not required by the small group market. These benchmark plans would likely be too broad, unaffordable, and wasteful, placing further burdens upon small businesses and the Commonwealth.

We agree that Virginia should continue to analyze which of the two between the small group market and the non-Medicaid HMO is least expensive to set as Virginia's benchmark. The essential health benefits package should incorporate cost considerations by evaluating benefits, including state benefit mandates, from both a cost and medical effectiveness perspective. In order to ensure affordability, Virginia should include in its review an analysis of our most costly mandated benefits.

In fact, we suggest that Virginia should set several goals: 1) identify the costs of the Commonwealth's mandated benefits using cost-benefit analysis; 2) once you know the costs - set a cost target that is affordable; and 3) set a goal of lowering that cost target. We can't just tread water – eventually we'll drown under the increased costs – we'll need to re-evaluate mandated benefits for health reform to succeed.

Like the IOM's recently issued recommendations, we agree that "current state mandated benefit laws should not automatically be included in the essential health benefits package…but should be reviewed in the same manner as other potential health benefits."

The IOM also recommended that included essential benefits "protect against the greatest financial risks due to catastrophic events or illnesses." Many state mandated benefits do not meet this criterion. They impose additional costs which make health insurance less affordable for everyone.

The EHB package should not dictate cost sharing requirements. In adopting the benchmark approach, the EHB package of the benchmark defines the services that must be covered, not the way in which those services must be covered, e.g., hospital and physician services. The benchmark does not define how specific cost-sharing requirements will be applied by health plans. The EHB package was never intended to define allowed cost-sharing, some of which is mandated in other provisions of the ACA; instead, the actuarial value requirement will shape how issuers design their cost-sharing requirements.

Consistent with existing typical employer plans and the structure of their benefits, any benchmark for essential benefits must not prohibit the use of current limits on state benefit mandates. Under the Bulletin's described benchmark approach, every service covered by a plan selected as a benchmark appears to be "essential," and allowing the provision of these services without the benefit limits already in place at the time of the plan's designation as a benchmark would have significant cost ramifications. The EHB package should promote flexibility and innovation in benefit design, including flexibility in applying appropriate treatment and benefit limitations to keep coverage affordable for consumers. Any prohibition on the continued use of such limits will increase the price – and thus the actuarial value and affordability – of the subsequent Qualified Health Plan (QHP) products.

Conclusion

Here are the main points I want to leave you with –

An essential health benefits (EHB) package must be affordable.

- Cost continues to be the biggest barrier for individuals and employers to obtain coverage; therefore it is critical that the basic package is affordable.

- The package should provide services that Virginians need to protect their health – and not coverage for every treatment we might want.

- An EHB package should serve as a base of truly "essential" and affordable coverage. This will allow choice and opportunity to "build up" from there while ensuring that basic coverage is affordable.

An EHB package must provide flexibility that allows consumers to get coverage suited to their needs and budget.

- The EHB package must allow for flexibility in insurance design, and must not dictate cost sharing arrangements that limit consumer choice.

The development of an EHB package must consider the costs to our Commonwealth associated with and resulting from the package.

- Taxpayer costs will greatly increase if more employers are priced out of coverage, further threatening our fiscal future.

- Virginia will ultimately be financially responsible for its extensive mandates so it is important now and during the transition period to examine the impact of whether the mandates allow health care coverage to be affordable.